



“Good luck to all you GP principals who soldier on at the front line, daily going over the top, with as many support and back-up staff as you can muster. In my view, this open-ended contract, based on head count, is now a folly, a mirage.”

REFERENCE

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Resilience training, *really*?

‘Resilience training’ that includes yoga and mindfulness is one reason I despair of the RCGP.

It is unfashionable to say the good GPs burn out or leave. I regard delivering a surgery in the traditional ‘proper’ way, as a complex interaction between physical symptoms and emotions, held within the relationship of ongoing consultations with a nod to prevention and review of chronic illness, as now overwhelming. Reasons, aside from me being older, are multiple and discussed *ad infinitum*: increased workload; increased consultation rate; more intervention; people living longer; and they older and more frail. Secondary and community services are slipped into elastic, unmeasured, un-costed primary care.

Is burnout due to the GP becoming over-involved? If I could learn detached compassion, empathy without feeling, perform interpretive consultations without transference, then perhaps that would make me more resilient. However, my sense is that GPs who achieve this — who cheerfully meddle in their patients’ lives and deliver a decision in the space of 8–9 minutes — risk becoming patronising, judgemental, and formulaic.

In my view, if you do the job in the traditional way, it is an impossible burden. You will burn out. Clare Gerada’s ‘A new kind of doctor’ offers another, practical career path.¹ Pick jobs where your time and capacity are respected.

Who can honestly say they accept the current contract, based on one doctor and 1800–2000 list size, and consistently deliver a reasonable service? Good luck to all you GP principals who soldier on at the front line, daily going over the top, with as many support and back-up staff as you can muster. In my view, this open-ended contract, based on head count, is now a folly, a mirage.

At Care UK, I can do a 5-hour shift and see patients at 15-minute intervals. They give me catch-up time, breaks, and double for mental health issues. There are no past medical records but every single patient is triaged and there is definitely one problem per slot.

As a locum, I can set my surgery length

and ensure that, for every 150-minute surgery, there is an hour for catch up and admin — just for the 12–15 people seen.

These doable sessions are not available in daytime general practice, not for GPs and sometimes not for nurse practitioners either.

Many colleagues feel they have to sit it out for the sake of primary care, for the sake of our patients, for ‘continuity’. Has no one explained? General practice is being dismantled, just like the coal mines were.

We were generalists but the future will hold primary care specialists. These may be nurses, for instance, managing chronic diseases in an improved, patient-centred way. Surgical trainees will be in urgent care, adjacent to A&E. Community geriatricians will work in teams managing frail older people. Pharmacists will oversee the increasingly complex prescribing seen among the over-50s.

The RCGP, as well as our LMCs, understand this direction of travel, another reason for my distrust. What will be left for us old-style GPs are patients with chronic pain, MUPS, and other complex or multiple morbidities. These are the patients who are at most risk of falling further through the net of our new, Kaiser-style, NHS.

The NHS no longer wants us to do this work. Our targets are aimed at responding promptly to inter-current illness, reducing the risk of heart disease, managing chronic disease, supporting the informal carer, picking up cancer early, and keeping the healthy fit. Our health service is in re-design, to keep well people at work and in pace with available technologies.

The complex consultation that we struggled to learn and hone could hold, contain, and help our most needy patients. This work, rewarding while creating the risk of GP burnout, is now history.

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